TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAMEER FINO MD

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-15-4083-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual is stating that they sent a certified letter on December 16, 2014 asking for a refund. The letter was never signed for and we did not receive it. They then state that on January 26, 2015 that a letter was sent by regular mail. We do not remember seeing that letter. Then on March 3, 2015, we did receive and sign for a certified copy of the request for refund.

On March 18 and 19 2015 the requests for appeal of refunds were faxed to Ms. Kyle Ringger, who was the bill reviewer. They were then mailed to her on March 24, 2015.

We received a denial of appeal dated April 8, 2015. They stated that we had to appeal before February 4, 2015. If we never received notification until March 3, 2015 and we have 45 days to appeal why do they consider it to [sic] late to appeal. They have no proof that we ever received notification of the first letter or the mailed one. So legally would that not be our first notification on March 3, 2015? We have stated the process again and are requesting a review. We are also appealing that this service was Medically Necessary."

Amount in Dispute: $299.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On April 8, 2015, Texas Mutual responded to the requestor's appeal of the refund request. The Notice of Determination stated the refund as denied for timeliness and independent reasons. The independent reasons were that the treatment was not in accordance with the ODG... The treatment provided in this case, CPT Code 95923, is not a recommended procedure. The services were not preauthorized and no emergency has been asserted. Therefore, Texas Mutual is entitled to a decision in its favor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2014	95923	$299.61	$299.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 sets out the definitions for general rules for medical billing and processing.
3. 28 Texas Administrative Code §133.230 sets out the guidelines for Insurance Carrier Audit of a Medical Bill.
4. 28 Texas Administrative Code §133.240 sets out the guidelines for Medical Payments and Denials.
5. Texas Labor Code Section 408.0271 sets out the law for Reimbursement by Health Care Provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 424 – Overpayment recoupment
   - 762 – Not ODG recommended treatment
   - 195 – Refund issued to an erroneous propriety Payer for this claim/service. Promptly remit the refund and a copy of this notification to the address above, attn: Medical Refunds

Issues

1. Does Texas Labor Code Section 408.0271 apply to this dispute?
2. Did the insurance carrier request a refund in accordance with 28 Texas Administrative Code, Chapter 133?
3. Is the requestor entitled to the amount of the refund paid to the insurance carrier?

Findings

1. The health care provider seeks a refund paid to the insurance carrier in the amount of $299.61 for a service rendered on September 30, 2014. The insurance carrier's request for a refund identified on the Explanation of Benefits (EOBs), states, "424 – Overpayment recoupment", "762 – Not ODG recommended treatment", and "195 – Refund issued to an erroneous propriety Payer for this claim/service. Promptly remit the refund and a copy of this notification to the address above, attn: Medical Refunds."

   Texas Labor Code Section 408.0271 states, "(a) If the health care services provided to an injured employee are determined by the insurance carrier to be inappropriate, the insurance carrier shall: (1) notify the health care provider in writing of the carrier's decision; and (2) demand a refund by the health care provider of the portion of payment on the claim that was received by the health care provider for the inappropriate services. (b) The health care provider may appeal the insurance carrier's determination under Subsection (a). The health care provider must file an appeal under this subsection with the insurance carrier not later than the 45th day after the date of the insurance carrier's request for the refund. The insurance carrier must act on the appeal not later than the 45th day after the date on which the provider files the appeal. (c) A health care provider shall reimburse the insurance carrier for payments received by the provider for inappropriate charges not later than the 45th day after the date of the carrier's notice. The failure by the health care provider to timely remit payment to the carrier constitutes an administrative violation."

   28 Texas Administrative Code §133.307 states, "(b) Requestors. The following parties may be requestors in medical fee disputes: (2) the provider in a dispute about the results of a Division or carrier audit or review which requires the provider to refund an amount for health care services previously paid by the insurance carrier."

   28 Texas Administrative Code §133.307 states, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (B) A request may be filed later than one year after the date(s) of service if: ((iii) the dispute relates to a refund notice issued pursuant to a Division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice."

2. Per 28 Texas Administrative Code §133.2, titled, *Definitions "*The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise: (6) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

   Review of the submitted documentation supports that the insurance carrier issued payment to the requestor that makes the total reimbursement for that bill paid in accordance with 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §133.230, titled, *Insurance Carrier Audit of a Medical Bill* states, "(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action."

28 Texas Administrative Code §133.240, titled, *Medical Payments and Denials* states, "(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

28 Texas Administrative Code §133.240 states, "(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title."

28 Texas Administrative Code §133.240 states,"(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title."

3. Review of the submitted documentation supports that the insurance carrier took final action on a complete medical bill and provided the requestor an EOB recommending payment. Further review of the documentation supports that the insurance carrier unilaterally conducted a bill review on a complete medical bill, which it had taken final action on.

   The Division finds that the insurance carrier may not unilaterally conduct a bill review on a medical bill the insurance carrier has taken final action on, pursuant to 28 Texas Administrative Code §133.240. As a result, the requestor is entitled to reimbursement as originally recommended and paid by the insurance carrier in the amount of $299.61.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $299.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $299.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 2, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.